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(E) DME—Orthotic Devices: DME/supplies.

(F) DME—Oxygen and Supplies: DME/supplies.

(G) DME—Wheelchairs: DME/supplies.

(H) Other DME: DME/supplies.

(I) Enteral/Parenteral Supplies: DME/supplies.

(J) Surgical Dressings and Supplies: DME/supplies.

(K) Vision Items—Other Than Lenses: DME/supplies.

(L) Vision Items—Lenses: DME/supplies.

(M) Hearing Items: DME/supplies.

(ii) *Area-specific weighted average charges.* Using the median charges by HCPCS code from the MDR database for each geographic area and utilization frequencies by HCPCS code from the combined Part B and DME components of the Medicare Standard Analytical File 5 percent Sample, an area-specific weighted average charge is calculated for each combined HCPCS code group.

(iii) *Nationwide weighted average charges.* Using the area-specific weighted average charges determined pursuant to paragraph (1)(5)(ii) of this section, a nationwide weighted average charge is calculated for each combined HCPCS code group, using as weights the population (census) frequencies for each geographic area as presented in the Milliman USA, Inc., Health Cost Guidelines (see paragraph (a)(3) of this section for Data Sources).

(m) *Charges for prescription drugs not administered during treatment.* Notwithstanding other provisions of this section regarding VA charges, when VA provides or furnishes prescription drugs not administered during treatment, within the scope of care referred to in paragraph (a)(1) of this section, charges billed separately for such prescription drugs will consist of the amount that equals the total of the actual cost to VA for the drugs and the national average of VA administrative costs associated with dispensing the drugs for each prescription. The actual VA cost of a drug will be the actual amount expended by the VA facility for the purchase of the specific drug. The administrative cost will be determined annually using VA's managerial cost

accounting system. Under this accounting system, the average administrative cost is determined by adding the total VA national drug general overhead costs (such as costs of buildings and maintenance, utilities, billing, and collections) to the total VA national drug dispensing costs (such as costs of the labor of the pharmacy department, packaging, and mailing) with the sum divided by the actual number of VA prescriptions filled nationally. Based on this accounting system, VA will determine the amount of the average administrative cost annually for the prior fiscal year (October through September) and then apply the charge at the start of the next calendar year.

NOTE TO § 17.101: The charges generated by the methodology set forth in this section are the same charges prescribed by the Office of Management and Budget for use under the Federal Medical Care Recovery Act, 42 U.S.C. 2651–2653.

(Authority: 38 U.S.C. 101, 501, 1701, 1705, 1710, 1721, 1722, 1729)

(The Office of Management and Budget has approved the information collection requirements in this section under control number 2900–0606)

[68 FR 70715, Dec. 19, 2003, as amended at 69 FR 1061, Jan. 7, 2004; 72 FR 68072, Dec. 4, 2007; 75 FR 61623, Oct. 6, 2010]

§ 17.102 Charges for care or services.

Except as provided in § 17.101, charges at the indicated rates shall be made for Department of Veterans Affairs hospital care or medical services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) as follows:

(a) *Furnished in error or on tentative eligibility.* Charges at rates prescribed by the Under Secretary for Health shall be made for inpatient or outpatient care or services (including domiciliary care) authorized for any person on the basis of eligibility as a veteran or a tentative eligibility determination under § 17.34 but he or she was subsequently found to have been ineligible for such care or services as a veteran because the military service or any other eligibility requirement was not met, or

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(b) *Furnished in a medical emergency.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered any person in a medical emergency who was not eligible for such care or services as a veteran, if:

(1) The care or services were rendered as a humanitarian service, under § 17.43(b)(1) or § 17.95 to a person neither claiming eligibility as a veteran nor for whom the establishment of eligibility as a veteran was expected, or

(2) The person for whom care or services were rendered was a Department of Veterans Affairs employee or a member of a Department of Veterans Affairs employee's family; or

(c) *Furnished beneficiaries of the Department of Defense or other Federal agencies.* Except as provided for in paragraph (f) of this section and the second sentence of this paragraph, charges at rates prescribed by the Office of Management and Budget shall be made for any inpatient or outpatient care or services authorized for a member of the Armed Forces on active duty or for any beneficiary or designee of any other Federal agency. Charges for services provided a member or former member of a uniformed service who is entitled to retired or retainer pay, or equivalent pay, will be at rates prescribed by the Secretary (E.O. 11609, dated July 22, 1971, 36 FR 13747), or

(d) *Furnished pensioners of allied nations.* Charges at rates prescribed by the Under Secretary for Health shall be made for any inpatient or outpatient care or services rendered a pensioner of a nation allied with the United States in World War I and World War II; or

(e) *Furnished under sharing agreements.* Charges at rates agreed upon in an agreement for sharing specialized medical resources shall be made for all medical care or services, either on an inpatient or outpatient basis, rendered to a person designated by the other party to the agreement as a patient to be benefited under the agreement; or

(f) *Furnished military retirees with chronic disability.* Charges for subsistence at rates prescribed by the Under Secretary for Health shall be made for the period during which hospital care

is rendered when such care is rendered to a member or former member of the Armed Forces required to pay the subsistence rate under § 17.47 (b)(2) and (c)(2).

(g) *Furnished for research purposes.* Charges will not be made for medical services, including transportation, furnished as part of an approved Department of Veterans Affairs research project, except that if the services are furnished to a person who is not eligible for the services as a veteran, the medical care appropriation shall be reimbursed from the research appropriation at the same rates used for billings under paragraph (b) of this section.

(h) *Computation of charges.* The method for computing the charges under § 17.86 and under paragraphs (a), (b), (d), (f), and (g) and the last sentence of paragraph (c) of this section is based on the Monthly Program Cost Report (MPCR), which sets forth the actual basic costs and per diem rates by type of inpatient care, and actual basic costs and rates for outpatient care visits or prescriptions filled. Factors for depreciation of buildings and equipment and Central Office overhead are added, based on accounting manual instructions. Additional factors are added for interest on capital investment and for standard fringe benefit costs covering government employee retirement and disability costs. The current year billing rates are projected on prior year actual rates by applying the budgeted percentage increase. In addition, based on the detail available in the MPCR, VA intends to, on each bill break down the all-inclusive rate into its three principal components; namely, physician cost, ancillary services cost, and nursing, room and board cost. The rates generated by the foregoing methodology will be published by

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either VA or OMB in the 'Notices' section of the FEDERAL REGISTER.

(Authority: 38 U.S.C. 1729; sec. 19013, Pub. L. 99-272)

[32 FR 11382, Aug. 5, 1967, as amended at 34 FR 7807, May 16, 1969; 35 FR 11470, July 17, 1970; 36 FR 18794, Sept. 22, 1971; 47 FR 50861, Nov. 10, 1982; 47 FR 58249, Dec. 1982; 52 FR 3010, Jan. 30, 1987. Redesignated and amended at 61 FR 21965, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997. Redesignated and amended at 64 FR 22678, 22683, Apr. 27, 1999; 69 FR 1061, Jan. 7, 2004; 73 FR 26946, May 12, 2008]

§ 17.103 Referrals of compromise settlement offers.

Any offer to compromise or settle any charges or claim for \$20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *To Chiefs of Fiscal activities.* If the debt represents charges made under § 17.101(a), the compromise offer shall be referred to the Chief of the Fiscal activity of the facility for application of the collection standards in § 1.900 *et seq.* of this chapter, provided:

(1) The debt does not exceed \$1,000, and

(2) There has been a previous denial of waiver of the debt by a field station Committee on Waivers and Compromises.

(b) *To Regional Counsel.* If the debt in any amount represents charges for medical services for which there is or may be a claim against a third party tort-feasor or under workers' compensation laws or Pub. L. 87-693; 76 Stat. 593 (see § 1.903 of this chapter) or involves a claim contemplated by § 1.902 of this chapter over which the Department of Veterans Affairs lacks jurisdiction, the compromise offer (or request for waiver or proposal to terminate or suspend collection action) shall be promptly referred to the field station Regional Counsel having jurisdiction in the area in which the claim arose, or

(c) *To Committee on Waivers and Compromises.* If one of the following situations contemplated in paragraph (c)(1) through (3) of this section applies

(1) If the debt represents charges made under § 17.101(a), but is not of a

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type contemplated in paragraph (a) of this section, or

(2) If the debt represents charges for medical services made under § 17.101(b), or

(3) A claim arising in connection with any transaction of the Veterans Health Administration for which the instructions in paragraph (a) or (b) of this section or in § 17.105(c) are not applicable, then, the compromise offer should be referred for disposition under § 1.900 *et seq.* of this chapter to the field station Committee on Waivers and Compromises which shall take final action.

[39 FR 26403, July 19, 1974, as amended at 47 FR 58250, Dec. 30, 1982. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996; 62 FR 17072, Apr. 9, 1997]

§ 17.104 Terminations and suspensions.

Any proposal to suspend or terminate collection action on any charges or claim for \$20,000 or less asserted by the Department of Veterans Affairs in connection with the medical program shall be referred as follows:

(a) *Of charges for medical services.* If the debt represents charges made under § 17.101 (a) or (b) questions concerning suspension or termination of collection action shall be referred to the Chief of the Fiscal activity of the station for application of the collection standards in § 1.900 *et seq.* of this chapter, or

(b) *Of other debts.* If the debt is of a type other than those contemplated in paragraph (a) of this section, questions concerning suspension or termination of collection action shall be referred in accordance with the same referral procedures for compromise offers (except the Fiscal activity shall make final determinations in terminations or suspensions involving claims of \$150 or less pursuant to the provisions of § 1.900 *et seq.* of this chapter.)

[34 FR 7807, May 16, 1969, as amended at 39 FR 26403, July 19, 1974. Redesignated and amended at 61 FR 21966, 21967, May 13, 1996]

§ 17.105 Waivers.

Applications or requests for waiver of debts or claims asserted by the Department of Veterans Affairs in connection with the medical program generally